



Center for the Study of
Healthcare Provider Behavior

Using the Chronic Care Model To Improve Diabetes Care

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Outline and Objectives

1. Challenges in management of chronic conditions
2. Overview of the Chronic Care Model (CCM)
3. Implementing a CCM approach in VA and DoD care settings

Acknowledgment:

Wagner et al, *www.ImprovingChronicCare.org*



Part 1

Challenges in management of chronic conditions



Chronic disease in the US

- Estimated prevalence in US in 2004: 133 million (nearly 50% of population), projected to increase approximately 1% annually to 171 million by 2030
- Estimated prevalence among VA patients in 1999: 72%, representing 96% of total VA healthcare costs
- Diabetes ranked 4th in 1999, affecting 15.6% of VA patients, behind
 - HTN (36.8%)
 - IHD (16.4%)
 - arthritis (16.1%)



Challenges of chronic disease management

- Effective management requires ongoing care and prevention (vs. *reactive acute care*)
- Effective management requires full involvement of patients (vs. *passive role*)
- Clinical practice guidelines specify multiple actions and services delivered by multiple clinicians in a coordinated manner (vs. *traditional professional model care*)
- Effective management requires explicit planning, coordinating, monitoring and support



Challenges of chronic disease management (cont.)

How can we organize care to meet these needs?



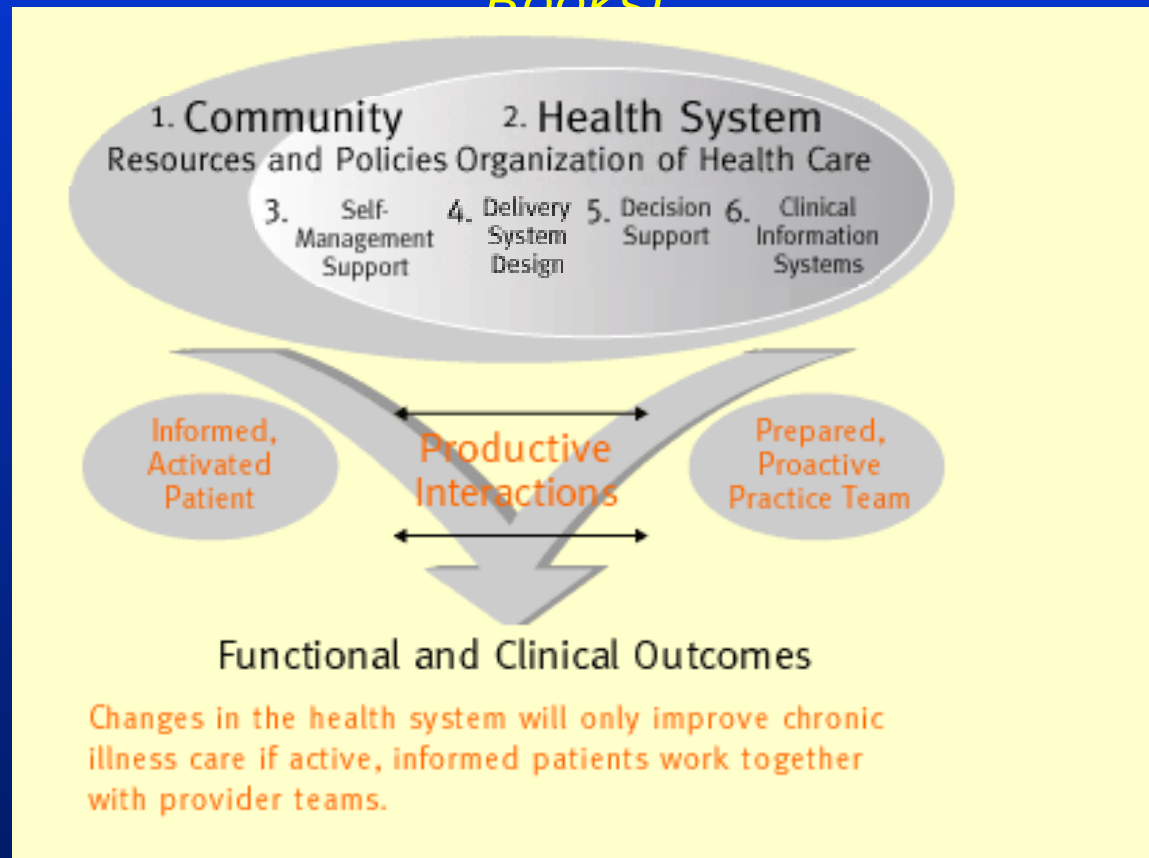
Part 2

Overview of the Chronic Care Model (CCM)



The Chronic Care Model

(copyright ACP-ASIM Journal and Books)



1. Community resources and policies

- External pressure and interest in improvement
- Patient education and social services
- Workplace support
- Research funding and advocacy



2. Health system -- organization of health care

- Leadership pressure and interest in improvement
- Promote and support improvement initiatives
- Infrastructure to encourage, enable care redesign



3. Self-management support

- Acknowledge patient's central role
- Train, support and encourage patient self-care
- Achieve collaborative partnership in care decisions, actions



4. Delivery system redesign

- Design efficient delivery system based on needs vs. resources
- Develop comprehensive plan to reorganize care, i.e., retrain, implement, monitor and support new procedures
- Recognize need for changes in culture, beliefs, attitudes and behaviors – in addition to professional practices



5. Decision support

- Develop point-of-care decision support (operationalizing evidence-based guidelines)
- Involve patients as additional mechanism of support



6. Clinical information systems

- Deploy information technology for:
 - Clinical decision support
 - Reminders (clinician and patient)
 - Patient identification and tracking (registries)
 - Care monitoring



Underlying principles

- Traditional professional model is limited and no longer optimal
- Organization and management theory offer frameworks and guidance, such as organization design/division of labor
- Complex packages of tasks require complex delivery system designs, allocating responsibility to clinicians, support staff, information technology, patients and family members, community resources, etc.



Part 3

Implementing a CCM approach in VA and DoD care settings



Governance: Initiating, planning, coordinating

- Interest in implementing a CCM approach may come from outside (VHA leadership, VSOs, Congress) or inside (facility leadership, clinical leadership, front-line staff)
- Support for implementation must span levels
- Representative governance is critical
- Diabetes educators may be most likely to *initiate*



CCM care delivery in VA and DoD MTFs

- Basic requirements are generally available (guidelines, IT, patient education, multi-disciplinary staff)
- Central elements (team care, coordination) are accepted
- Successful models are prevalent
- Technical assistance and consultation are available
- VA and DoD should (continue to) demonstrate national and international leadership and world-class performance

